Springfield Family Chiropractic PC

Name_____

7 E. Woodland Ave. ♦ Springfield, PA 19064 ♦ 610-544-6336 fax: 610-544-7059

Auto Injury Patient Information

Today's Date: / /

Date of Accident: / /

1. Personal Information:

First Name: Middle Initial: Last Name:

Date of Birth: Email:

Street Address: Home Phone:

City, State, Zip: Work Phone:

Dominant Hand: Right ❑ Left ❑ Both ❑

2. Insurance Information

Were you the driver: Yes ❑ No ❑

Part A: (If same as above, skip to Part B)

Insured's Name:

Insured's Address: Insured's Phone:

Insured's City, State, Zip:

Part B:

Insurance Company Name:

Policy #: Accident Claim #:

Insurance Company Phone #: ( )

Claims Mailing Address:

Adjuster's Name/Phone #:

3. Attorney Information

Check here if N/A ❑

Attorney's Name: Attorney's Phone:

Attorney's Street Address:

Attorney's City/State/Zip: Contact Name:

Additional Notes:

Name_____

Automobile Accident Description

Please answer the questions below. If you do not know the answer to any of the questions, do not answer that question.

1. Your vehicle type

❑Car ❑Station Wagon
❑Van ❑Pickup Truck
❑Large Truck ❑Bus

Other_____

2. Your position in vehicle

❑Driver ❑Front Passenger
❑Left Rear Passenger
❑Right Rear Passenger

Other_____

3. What was your vehicle doing at the time of the accident?

❑Stopped at intersection ❑Stopped in traffic ❑Stopped at light
❑Making a right turn ❑Making a left turn ❑Parking
❑Proceeding along ❑Slowing down ❑Accelerating

Other_____

4. Time/Speed/Damage

Time of accident_____
Your vehicle's speed: _____mph
Their vehicle's speed: _____mph

Damage to your vehicle
❑Mild ❑Moderate
❑Totaled

5. Details of Accident

Visibility at time of accident
❑Poor ❑Fair ❑Good

Who hit who/what?
❑You hit other vehicle
❑Other vehicle hit you
You hit...(object)

_____

6. Road conditions

Road conditions at time of accident
❑Icy ❑Wet ❑Sandy ❑Dark ❑Clean and dry

Point of impact
❑Head-On ❑Left Front ❑Right Front
❑Rear-End ❑Left Rear ❑Right Rear

7. Body Position, etc.

Did you see the accident coming? Yes ❑ ❑ No
Were you braced for the impact? Yes ❑ ❑ No
Did you have a seat belt on? Yes ❑ ❑ No
Did you have a shoulder harness on? Yes ❑ ❑ No

Does your vehicle have headrests? Yes ❑ ❑ No
What was the position of your headrest at the time of the impact:
❑ Even with top of head ❑ Even with bottom of head ❑ Middle of neck
What was the direction of your head at the time of impact:
❑ Facing straight forward ❑ Turned to the right ❑ Turned to the left

Did driver side air bags deploy? Yes ❑ ❑ No Did passenger side air bags deploy? Yes ❑ ❑ No Did side airbags deploy? Yes ❑ ❑ No

8. Additional accident information
In the case of a motor vehicle accident, enter any additional information here that is not covered by the above check offs.

9. During the accident:

Did your body strike inside of your vehicle? Yes ❑ ❑ No
If yes, describe:_____
Did you lose consciousness during the injury? Yes ❑ ❑ No
If yes, for how long? _____
Your vehicle's estimated damage? _____
Damage to their vehicle: ❑Mild ❑Moderate ❑Totaled
Did police show up at the scene? Yes ❑ ❑ No
Was an accident report filled out? Yes ❑ ❑ No

10. After the accident:

Check off your symptoms following the accident:
❑Headache ❑Dizziness ❑Mid back pain ❑Cold hands
❑Neck pain ❑Nausea ❑Low back pain ❑Cold feet
❑Neck stiffness ❑Confusion ❑Nervousness ❑Diarrhea
❑Fainting ❑Fatigue ❑Loss of taste ❑Depression
❑Ringing in ears ❑Tension ❑Toe numbness ❑Anxious
❑Loss of smell ❑Irritability ❑Constipation ❑Chest Pain
❑Pain behind eyes ❑Shortness of breath ❑Sleeping problems
Others:_____

11. Emergency Room?

Where did you go after the accident?
❑Home ❑Work ❑Hospital ER ❑Private Doctor
How did you get there?
❑Self ❑Somebody else ❑Ambulance ❑Police
X-rays done? Yes ❑ ❑ No **Lab work?** Yes ❑ ❑ No
Body parts X-rayed?_____
What lab work?_____
The X-rays revealed: _____
Treatments: ❑Cervical Collar ❑Ice **Other:**____
Medications:_____
Follow-up instructions: _____
_____

12. Treatment History:

Fill in other doctor(s) seen prior to your first visit to this office.
1. Dr. _____ First visit date: ____/____/____
Specialty:_____ X-rays done? Yes ❑ ❑ No
Types of treatmentsreceived:_____
How many treatments received? ____ Currently treating? Yes No
Did treatments benefit you?Yes ❑ ❑ No
Last visit date: ____/____/____
2. Dr. _____ First visit date: ____/____/____
Types of treatments received:_____
How many treatments received? ____ Currently treating: Yes No
Did treatments benefit you? Yes ❑ ❑ No
Last visit date: ____/____/____

Patient Name _____ Date: ___/___/___

Symptoms - Primary reason(s) for seeking care:

Location (Circle One):

Head Neck Upper back Mid back Low back
Buttocks Tailbone Jaw Shoulder Elbow
Wrist Hip Knee Ankle Foot Other _____

Type of Symptom (Circle All That Apply):

Aching Pain Dull Pain Sharp Pain Stabbing Pain
Burning Pain Stiff Weak Numb/Tingling
Radiating into: _____

Pain Level: 1 2 3 4 5 6 7 8 9 10

Which side? Left Right Both

How frequent? Constant Frequent Intermittent Occasional

Aggravated by: Bending Twisting Standing Sitting
Other: _____

Relieved by: Rest Heat Ice Pain Reliever
Other: _____

Location (Circle One):

Head Neck Upper back Mid back Low back
Buttocks Tailbone Jaw Shoulder Elbow
Wrist Hip Knee Ankle Foot Other _____

Type of Symptom (Circle All That Apply):

Aching Pain Dull Pain Sharp Pain Stabbing Pain
Burning Pain Stiff Weak Numb/Tingling
Radiating into: _____

Pain Level: 1 2 3 4 5 6 7 8 9 10

Which side? Left Right Both

How frequent? Constant Frequent Intermittent Occasional

Aggravated by: Bending Twisting Standing Sitting
Other: _____

Relieved by: Rest Heat Ice Pain Reliever
Other: _____

Location (Circle One):

Head Neck Upper back Mid back Low back
Buttocks Tailbone Jaw Shoulder Elbow
Wrist Hip Knee Ankle Foot Other _____

Type of Symptom (Circle All That Apply):

Aching Pain Dull Pain Sharp Pain Stabbing Pain
Burning Pain Stiff Weak Numb/Tingling
Radiating into: _____

Pain Level: 1 2 3 4 5 6 7 8 9 10

Which side? Left Right Both

How frequent? Constant Frequent Intermittent Occasional

Aggravated by: Bending Twisting Standing Sitting
Other: _____

Relieved by: Rest Heat Ice Pain Reliever
Other: _____

Location (Circle One):

Head Neck Upper back Mid back Low back
Buttocks Tailbone Jaw Shoulder Elbow
Wrist Hip Knee Ankle Foot Other _____

Type of Symptom (Circle All That Apply):

Aching Pain Dull Pain Sharp Pain Stabbing Pain
Burning Pain Stiff Weak Numb/Tingling
Radiating into: _____

Pain Level: 1 2 3 4 5 6 7 8 9 10

Which side? Left Right Both

How frequent? Constant Frequent Intermittent Occasional

Aggravated by: Bending Twisting Standing Sitting
Other: _____

Relieved by: Rest Heat Ice Pain Reliever
Other: _____

Oswestry Low Back Pain Disability Questionnaire

Instructions

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking ONE box in each section for the statement which best applies to you. We realise you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement which most clearly describes your problem.

SECTION 1: Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

SECTION 2: Personal Care (e.g. washing, dressing)

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help but can manage most of my personal care.
- I need help every day in most aspects of self-care.
- I do not get dressed, wash with difficulty and stay in bed.

SECTION 3: Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights, but it gives me extra pain.
- Pain prevents me from lifting heavy weights off the floor I can manage if they are conveniently placed (e.g., on a table.)
- Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights.
- I cannot lift or carry anything.

SECTION 4: Walking

- Pain does not prevent me walking any distance.
- Pain prevents me from walking more than 1 mile.
- Pain prevents me from walking more than 1/2 mile.
- Pain prevents me from walking more than 100 yards.
- I can only walk using a stick or crutches.
- I am in bed most of the time.

SECTION 5: Sitting

- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me sitting more than 1 hour.
- Pain prevents me from sitting more than 30 minutes.
- Pain prevents me from sitting more than 10 minutes.
- Pain prevents me from sitting at all.

SECTION 6: Standing

- I can stand as long as I want without extra pain.
- I can stand as long as I want but it gives me extra pain.
- Pain prevents me from standing more than 1 hour.
- Pain prevents me from standing for more than 30 minutes.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

SECTION 7: Sleeping

- My sleep is never disturbed by pain.
- Because of pain I have less than 6 hours sleep.
- Because of pain I have less than 4 hours sleep.
- Because of pain I have less than 2 hours sleep.
- Pain prevents me from sleeping at all.
- My sleep is occasionally disturbed by pain.

SECTION 8: Sex Life (if applicable)

- My sex life is normal and causes no extra pain.
- My sex life is normal but causes some extra pain.
- My sex life is nearly normal but is very painful.
- My sex life is severely restricted by pain.
- My sex life is nearly absent because of pain.
- Pain prevents any sex life at all.

SECTION 9: Social Life

- My social life is normal and gives me no extra pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sport.
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted my social life to my home.
- I have no social life because of pain.

SECTION 10: Traveling

- I can travel anywhere without pain.
- I can travel anywhere but it gives me extra pain.
- Pain is bad but I manage journeys over 2 hours.
- Pain restricts me to journeys of less than 1 hour.
- Pain restricts me to short necessary journeys under 30 minutes.
- Pain prevents me from traveling except to receive treatment.

Patient Name: Date: Score:

Neck Disability Index

This questionnaire has been designed to give us information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the one box that applies to you. We realise you may consider the two or more statements in any one section relate to you, but please just mark the box that most closely describes your problem.

SECTION 1: Pain Intensity

- I have no pain at the moment.
- The pain is mild at the moment.
- The pain comes and goes and is moderate.
- The pain is moderate and does not vary much.
- The pain is very severe, but comes and goes.
- The pain is severe and does not vary much.

SECTION 2: Personal Care (e.g. washing, dressing)

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help but can manage most of my personal care.
- I need help every day in most aspects of self-care.
- I do not get dressed, wash with difficulty and stay in bed.

SECTION 3: Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights, but it gives me extra pain.
- Pain prevents me from lifting heavy weights off the floor I can manage if they are conveniently placed (e.g., on a table.)
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights.
- I cannot lift or carry anything.

SECTION 4: Reading

- I can read as much as I want to with no neck pain.
- I can read as much as I want with slight neck pain.
- I can read as much as I want with moderate neck pain.
- I cannot read as much as I want because of moderate neck pain.
- I cannot read as much as I want because of severe neck pain.
- I cannot read at all.

SECTION 5: Headache

- I have no headaches at all.
- I have slight headaches which come infrequently
- I have moderate headaches which come infrequently.
- I have moderate headaches which come frequently.
- I have severe headaches which come frequently.
- I have headaches almost all the time.

SECTION 6: Concentration

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

SECTION 7: Work

- I can do as much work as I want to.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I cannot do any work at all.

SECTION 8: Driving

- I can drive my car without neck pain.
- I can drive my car as long as I want with slight pain in my neck.
- I can drive my car as long as I want with moderate pain in my neck.
- I cannot drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive my car at all because of severe pain in my neck.
- I cannot drive my car at all.

SECTION 9: Sleeping

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hour sleepless).
- My sleep is mildly disturbed (1-2 hours sleepless).
- My sleep is moderately disturbed (2-3 hours sleepless).
- My sleep is greatly disturbed (3-5 hours sleepless).
- My sleep is completely disturbed (5-7 hours sleepless)

SECTION 10: Recreation

- I am able to engage in all recreational activities with no pain in my neck at all.
- I am able to engage in all recreational activities with some pain in my neck.
- I am able to engage in most, but not all, recreational activities because of pain in my neck.
- I am able to engage in a few of my usual recreational activities because of pain in my neck.
- I can hardly do any recreational activities because of pain in my neck.
- I cannot do any recreational activities at all.

Patient Name: Date: Score:

Springfield Family Chiropractic, P.C.
Dr. Gary S. Miller
7 E. Woodland Avenue
Springfield, PA 19064

Patient Name: _____

Authorization for Assignment and Records Release

I authorize Springfield Family Chiropractic PC to:

1. Release medical records concerning my physical condition to my insurance company, attorney or adjuster in order to process a claim for payment of charges incurred.

2. Be paid directly for their services by my insurance company, attorney, or adjuster.

Payment of Non-Covered Services

In the event that I do not have insurance coverage for services rendered by Springfield Family Chiropractic PC, or my insurance company does not cover all services by Springfield Family Chiropractic PC, I agree to be personally responsible for payment.

Terms of Acceptance

When a patient comes to our office for chiropractic care and we accept a patient for such care, it is essential for both to be working toward the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. Chiropractic has only one goal – to remove vertebral subluxations.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of neural impulses.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation, nor do we offer advice regarding treatment prescribed by others. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will notify you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Privacy Notice

I acknowledge that I have received the *Notice of Privacy Practices*.

By signing below, I indicate that I have read and fully understand the above statements.

Signature: _____ Date: ____/____/_____

Springfield Family Chiropractic PC

NOTICE
OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Key Issues

Uses and Disclosures:

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Continuity of care is part of treatment and your records may be shared with other providers to whom you are referred. We may use or disclose identifiable health information about you without your authorization in several situations, but beyond those situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. Your rights: In most cases, you have the right to look at or get a copy of health information about you. If you request copies, we will charge you only normal photocopy fees. You also have the right to receive a list of certain types of disclosures of your information that we made. If you believe that information in your record is incorrect, you have the right to request that we correct the existing information.

Our legal duty:

We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice, and seek your acknowledgement of receipt of this notice. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints:

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

If you have any questions or complaints, please contact:

Jeanne Miller
7 E. Woodland Ave.
Springfield, PA 19064
610-544-6336

Further Details

1. Uses and Disclosures of Protected Health Information

Following are examples of the types of uses and disclosures of your protected health care information that the provider is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. For example, your protected health information may be provided to a doctor to whom you have been referred to ensure that the doctor has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, in activities related to obtaining payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to your health insurance company or governmental plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support our business activities. For example, when we review employee performance, we may need to look at what an employee has documented in your medical record.

Business Associates: We may share your protected health information with a third party 'business associate' that performs various activities (e.g., billing, transcription services). Whenever an arrangement between us and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Marketing: We may use or disclose certain health information in the course of providing you with information about treatment alternatives, health-related services, or fund-raising. You may contact us to request that these materials not be sent to you.

Written Authorization: Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke your authorization, at any time, in writing.

Opportunity to Object: We may use and disclose your protected health information in the following instances. You have the opportunity to object. If you are not present or able to object, then your provider may, using professional judgment, determine whether the disclosure is in your best interest.
Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care.
Emergencies: In an emergency treatment situation, we will provide you a Notice of Privacy Practices as soon as reasonably practicable after the delivery of treatment.
Communication Barriers: We may use and disclose your protected health information if we have attempted to obtain acknowledgement from you of our Notice of Privacy Practices but have been unable to do so due to substantial communication barriers and we determine, using professional judgment, that you would agree.
Without Opportunity to Object:We may use or disclose your protected health information in the following situations without your authorization or opportunity to object:
Public Health: for public health purposes to a public health authority or to a person who is at risk of contracting or spreading your disease.
Health Oversight: to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.
Abuse or Neglect: to an appropriate authority to report child abuse or neglect, if we believe that you have been a victim of abuse, neglect, or domestic violence.
Legal Proceedings: in the course of legal proceedings.
Law Enforcement: for law enforcement purposes, such as pertaining to victims of a crime or to prevent a crime.
Coroners, Funeral Directors, and Organ Donation: for the coroner, medical examiner, or funeral director to perform duties authorized by law and for organ donation purposes.
Research: to researchers when their research has been approved by an Institutional Review Board or Privacy Board.
Soldiers, Inmates, and National Security: to military supervisors of Armed Forces personnel or to custodians of inmates, as necessary. Preserving national security may also necessitate disclosure of protected health information.
Workers' Compensation: to comply with workers' compensation laws.
Compliance: to the Department of Health and Human Services to investigate our compliance. In general, we may use or disclose your protected health information as required by law and limited to the relevant requirements of the law.

2. Your Rights

You have the right to:

- inspect and copy your protected health information.
- request a restriction of your protected health information. You may ask us not to use or disclose certain parts of your protected health information for treatment, payment or healthcare operations. You may also request that information not be disclosed to family members or friends who may be involved in your care. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to a restriction that you may request, but if we do agree, then we must act accordingly.
- request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request.
- ask us to amend your protected health information. You may request an amendment of protected health information about you. If we deny your request for amendment, you have the right to file a statement of disagreement with us, and your medical record will note the disputed information.
- receive an accounting of certain disclosures we may have made. This right applies to disclosures for purposes other than treatment, payment or healthcare operations. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures. The right to receive this information is subject to certain exceptions, restrictions and limitations.
- obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.